Chapter 4.5
Division of Workers' Compensation
Subchapter 1
Administrative Director-Administrative Rules

Article 1.1
Workers' Compensation Information System

9701. Definitions

The following definitions apply in this article:

(a) Bona Fide Statistical Research. The analysis of existing workers' compensation data for the purpose of developing or contributing to basic knowledge regarding the California workers' compensation system.

~~(a)~~ (b) Claim. An injury as defined in Division 4 of the Labor Code, occurring on or after March 1, 2000, that has resulted in the receipt of one or more of the following by a claims administrator:

(1) Employer's Report of Occupational Injury or Illness, as required by Title 8, California Code of Regulations §§ 14004-14005.

(2) Doctor's First Report of Occupational Injury or Illness, as required by Title 8, California Code of Regulations §§ 14006-14007.

(3) Application for Adjudication filed with the Workers' Compensation Appeals Board under Labor Code § 5500 and Title 8, California Code of Regulations § 10408.

(4) Any information indicating that the injury requires medical treatment by a physician as defined in Labor Code § 3209.3.

~~(b)~~ (c) Claims Administrator. A self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(d) Closed Claim. A claim in which future payment of indemnity benefits and/or provision of medical benefits cannot be reasonably expected to be due.

~~(c)~~ (e) Data Elements. Information identified by data number (DN) and defined in the dictionary of the EDI Implementation Guide, Release 1, or the EDI Implementation

Guide, Release 2. Data elements set forth in Section 9702 must be transmitted on all claims, where applicable, as indicated in Section 9702. The data elements set forth in the EDI Implementation Guides that are not enumerated in Section 9702 are optional and may, but need not be, submitted on any or all claims.

~~(d)~~ (f) Electronic Data Interchange. ("EDI"). A computer to computer exchange of data or information in a standardized format acceptable to the Administrative Director.

~~(e)~~ (g) EDI Implementation Guide, Release 1. EDI Implementation Guide for First, Subsequent, Acknowledgment Detail, Header & Trailer Records, Release I, issued August 9, 1995, by the International Association of Industrial Accident Boards and Commissions. Sections 4, 5, 6, and the Appendix of EDI Implementation Guide, Release 1, are hereby incorporated by reference.

~~(f)~~ (h) EDI Implementation Guide, Release 2. EDI Implementation Guide for First, Subsequent, Acknowledgment Detail, Header & Trailer Records, Release 2, issued ~~November 30, 1998~~ December 1, 1999, by the International Association of Industrial Accident Boards and Commissions. Sections 4, 5, 6, and the Appendix of EDI Implementation Guide, Release 2, are hereby incorporated by reference.

(i) EDI Medical Bill/Payment Report Implementation Guide. EDI Implementation Guide for Medical Bill/Payment Report, Release 1, approved July 4, 2002, by the International Association of Industrial Accident Boards and Commissions. Sections 1 through 3, and 6 through 14 of the EDI Implementation Guide for Medical Bill/Payment Report, Release 1, are hereby incorporated by reference.

~~(g)~~ (j) EDI Trading Partner Profile. The form, required to be completed by the claims administrator, which sets forth the conditions under which the trading of data elements is to take place. The EDI Trading Partner Profile [Form DWC WCIS TP01 ~~(Revised 4/99)~~ (Revised 11/00), entitled "Electronic Data Interchange Trading Partner Profile"], is hereby incorporated by reference.

~~(h) Reserved for future rulemaking upon issuance of the EDI Medical Bill/Payment Report Implementation Guide by the International Association of Industrial Accident Boards and Commissions.~~

(k) Health Care Organization ("HCO"). Any entity certified as a health care organization by the Administrative Director pursuant to Labor Code Sections 4600.5 and 4600.6.

~~(i)~~ (l) Indemnity Benefits. Payments conferred, including those made by settlement, for any of the following: temporary disability indemnity, permanent disability

indemnity, death benefits, vocational rehabilitation maintenance allowance, and employer-paid salary in lieu of compensation.

~~(j)~~ (m) Individually Identifiable Information. Any data concerning an injury or claim that is linked to a uniquely identifiable employee, employer, claims administrator, or any other person or entity.

~~(k) Reserved.~~

~~(l)~~(n) International Association of Industrial Accident Boards and Commissions ("IAIABC"). A professional association of workers' compensation specialists, located at ~~1201 Wakarusa Drive, C-3, Lawrence, Kansas 66049~~ 5610 Medical Circle, Suite 14, Madison, Wisconsin 53711, which is, in addition to other activities, engaged in the production and publication of EDI standards for filing workers' compensation information. Note: IAIABC asserts ownership of such EDI standards which are published in various ways and include Implementation Guides with instructions on their use, technical and business specifications and coding information to permit the transfer of data between regulatory bodies and regulated entities in a uniform and consistent manner. Users of these standards are advised to contact IAIABC regarding any applicable licensing arrangements.

~~(m)~~(o) WCIS. The Workers' Compensation Information System established pursuant to sections 138.6 and 138.7 of the Labor Code.

Authority: Sections 133, 138.6, and 138.7, Labor Code.
Reference: Section 138.6 and 138.7, Labor Code.

9702. Electronic Data Reporting

(a) Each claims administrator shall transmit data elements, by electronic data interchange, to the WCIS by the dates specified in this section. Each claims administrator shall, at a minimum, provide complete, valid, accurate data for the data elements set forth in this section. The data elements required in this section are taken from EDI Implementation Guide, Release 1, and EDI Implementation Guide, Release 2. Claims administrators utilizing EDI Implementation Guide, Release 1, shall only transmit the data elements that are set forth in Release 1. Claims administrators utilizing EDI Implementation Guide, Release 2, shall only transmit the data elements that are set forth in Release 2. Each transmission of data elements shall include appropriate header and trailer records as set forth in the applicable EDI Implementation Guide.

~~(1) The Administrative Director, upon request, may grant a claims administrator a variance in reporting all or part of the data elements required pursuant to Subsections (b) and (d) of this section. Any variance granted by the Administrative Director under this subsection shall be set forth in writing. This variance shall be granted upon:~~

~~(A) a documented showing that compliance with the reporting deadlines set forth in Subsections (b) and (d) would cause undue hardship to the claims administrator; and~~

~~(B) submission of a plan, prior to the applicable deadline set forth in Subsection (b) and (d), documenting the means by which the claims administrator will ensure full compliance with the data reporting by January 1, 2001.~~

~~(2) "Undue hardship" means that compliance with the applicable reporting deadline would result in significant difficulty or expense for the claims administrator.~~

~~(3) A claims administrator which certifies that the data reporting deadline set forth in subdivision (b) cannot be met because a computer system critical to carry out its mission is not yet capable of sending, receiving, or calculating data that contains dates after December 31, 1999 shall be deemed to have shown undue hardship for the purposes of paragraph (1).~~

~~(4) The variance period for reporting data elements under Subsections (b) and (d) will end on December 31, 2000. A claims administrator granted a variance shall submit to the WCIS by January 1, 2001 all data that were required to be submitted under Subsections (b) and (d) during the variance period except for data that were not known to the claims administrator or not captured on the claims administrator's electronic data systems. The data shall be submitted in an electronic format acceptable to the Division.~~

(b) ~~On and after March 1, 2000, e~~Each claims administrator shall submit to the WCIS on each claim, within five (5) business days of knowledge of the claim, each of the following data elements known to the claims administrator:

DATA ELEMENT NAME	DN
MAINTENANCE TYPE CODE	2
MAINTENANCE TYPE CODE DATE	3
JURISDICTION CODE (1)	4
INSURER FEIN	6
INSURER NAME	7
THIRD PARTY ADMINISTRATOR FEIN (2)	8
THIRD PARTY ADMINISTRATOR NAME (2)	9
CLAIM ADMINISTRATOR MAILING PRIMARY ADDRESS (1)	10
CLAIM ADMINISTRATOR MAILING SECONDARYADDRESS (1)	11
CLAIM ADMINISTRATOR MAILING CITY (1)	12
CLAIM ADMINISTRATOR MAILING STATE CODE (1)	13
CLAIM ADMINISTRATOR MAILING POSTAL CODE (1)	14
CLAIM ADMINISTRATOR CLAIM NUMBER	15
EMPLOYER FEIN (3)	16
EMPLOYER NAME	18
EMPLOYER PHYSICAL PRIMARY ADDRESS (1)	19
EMPLOYER PHYSICAL SECONDARY ADDRESS (1)	20
EMPLOYER PHYSICAL CITY (1)	21
EMPLOYER PHYSICAL STATE CODE (1)	22
EMPLOYER PHYSICAL POSTAL CODE (1)	23

SELF INSURED INDICATOR (4)	24
DATE OF INJURY	31
ACCIDENT SITE POSTAL CODE (1)	33
NATURE OF INJURY CODE	35
PART OF BODY INJURED CODE	36
CAUSE OF INJURY CODE	37
ACCIDENT/INJURY DESCRIPTION NARRATIVE (1)	38
DATE EMPLOYER HAD KNOWLEDGE OF THE INJURY (1)	40
DATE CLAIM ADMINISTRATOR HAD KNOWLEDGE OF THE INJURY (1)	41
EMPLOYEE SSN (1) (5)	42
EMPLOYEE LAST NAME	43
EMPLOYEE FIRST NAME	44
EMPLOYEE MIDDLE NAME/INITIAL (1) (5)	45
EMPLOYEE MAILING PRIMARY ADDRESS (1) (5)	46
EMPLOYEE MAILING SECONDARY ADDRESS (1) (5)	47
EMPLOYEE MAILING CITY (1) (5)	48
EMPLOYEE MAILING STATE CODE (1) (5)	49
EMPLOYEE MAILING POSTAL CODE (1) (5)	50
EMPLOYEE PHONE NUMBER (1) (5)	51
EMPLOYEE DATE OF BIRTH	52
EMPLOYEE GENDER CODE (1)	53
EMPLOYEE MARITAL STATUS CODE (1) (6)	54
EMPLOYEE NUMBER OF DEPENDENTS (1) (6)	55
INITIAL DATE DISABILITY BEGAN (1)	56
EMPLOYEE DATE OF DEATH (6)	57
EMPLOYMENT STATUS CODE (5)	58
MANUAL CLASSIFICATION CODE (1) (7)	59
OCCUPATION DESCRIPTION	60
EMPLOYEE DATE OF HIRE (1) (5)	61
AVERAGE WAGE (1) (5)	62
WAGE PERIOD CODE (1) (5)	63
INITIAL DATE LAST DAY WORKED (1)	65
SALARY CONTINUED IN LIEU OF COMPENSATION INDICATOR (1)	67
INITIAL RETURN TO WORK DATE (1)	68
EMPLOYEE MAILING COUNTRY CODE (5) (8)	155
INSURED TYPE CODE (8)	184
CLAIM ADMINISTRATOR FEIN (8)	187
CLAIM ADMINISTRATOR NAME (8)	188
RETURN TO WORK TYPE CODE (8)	189
PHYSICAL RESTRICTIONS INDICATOR (8)	224
EMPLOYER UI NUMBER (3) (8)	329

(1) Release 1 data element name differs.
(2) Release 1 only ~~; not required for claims with a date of injury after July 1, 2000~~.
(3) EMPLOYER FEIN (DN 16) and EMPLOYER UI NUMBER (DN 329) are substitutable; only one is required.
(4) For Release 1 only; for Release 2 substitute INSURED TYPE CODE (DN 184).
(5) Required only when provided to the claims administrator.
(6) Death Cases Only.
(7) Required for insured claims only; optional for self-insured claims.
(8) For Release 2 only ~~; optional for claims with a date of injury before July 1,~~

~~2000~~.

Data elements omitted under this subsection because they were not known by the claims administrator shall be submitted within sixty (60) days from the date of the first report under this subsection.

(c) Each transmission of data elements listed under (b), (d), (e), (f), or (g) of this section shall also include the following elements for data linkage:

DATA ELEMENT NAME	DN
MAINTENANCE TYPE CODE (1)	2
MAINTENANCE TYPE CODE DATE (1)	3
JURISDICTION CLAIM NUMBER ~~(1)~~ (2) (3) (4)	5
INSURER FEIN (4)	6
THIRD PARTY ADMINISTRATOR FEIN (4)	8
CLAIM ADMINISTRATOR CLAIM NUMBER (2) (3) (4)	15
CLAIM ADMINISTRATOR FEIN (4)	187
DATE OF INJURY (2)	31
EMPLOYEE SSN (2)(3)	42
(1) Maintenance Type Code (DN 2) and Maintenance Type Code Date (DN 3) are required for transmissions under Subsections (b), (d), (f), and (g). ~~(1)~~ (2) This number will be provided by WCIS upon receipt of the first report. The Jurisdiction Claim Number (DN 5) is required when changing a Claim Administrator Claim Number (DN 15); it is optional for other transmissions under this subsection. ~~(2)~~ (3) The ~~Date of Injury (DN 31), Employee SSN (DN 42), and~~ Claim Administrator Claim Number (DN 15) need not be submitted if the Jurisdiction Claim Number (DN 5) accompanies the transmission, except for transmissions required under Subsection (f). (4) If the Jurisdiction Claim Number (DN 5) is not provided, both Claim Administrator Claim Number (DN 15) and Claim Administrator FEIN (DN 187) are required in Release 2. In Release 1, Third Party Administrator FEIN (DN 8) substitutes for Claim Administrator FEIN (DN 187), or, if there is no third party administrator, Insurer FEIN (DN 6) substitutes for Claim Administrator FEIN (DN 187).	

(d) ~~On and after July 1, 2000, e~~Each claims administrator shall submit to the WCIS within ten (10) business days the following data elements, whenever indemnity benefits of a particular type and amount are started, changed, suspended, restarted, stopped, delayed, or denied, or when a claim is closed or reopened, or when the claims administrator is notified of a change in employee representation. Submissions under this subsection are required only for claims with a date of injury on or after July 1, 2000, and

shall not include data on routine payments made during the course of an uninterrupted period of indemnity benefits.

DATA ELEMENT NAME	DN
EMPLOYMENT STATUS CODE	58
AVERAGE WAGE (1)	62
WAGE PERIOD CODE (1)	63
INITIAL RETURN TO WORK DATE (1)	68
DATE OF MAXIMUM MEDICAL IMPROVEMENT	70
CURRENT RETURN TO WORK DATE (1)	72
CLAIM STATUS CODE (1)	73
DATE CLAIM ADMINISTRATOR NOTIFIED OF EMPLOYEE REPRESENTATION (1)	76
LATE REASON CODE	77
PERMANENT IMPAIRMENT BODY PART CODE (2) (3)	83
PERMANENT IMPAIRMENT PERCENTAGE (1) (3)	84
BENEFIT TYPE CODE (1)	85
BENEFIT TYPE AMOUNT PAID (1)	86
NET WEEKLY AMOUNT (4)	87
BENEFIT PERIOD START DATE (1)	88
BENEFIT PERIOD THROUGH DATE (1)	89
BENEFIT TYPE CLAIM WEEKS (1)	90
BENEFIT TYPE CLAIM DAYS (1)	91
~~BENEFIT ADJUSTMENT CODE~~	~~92~~
~~BENEFIT ADJUSTMENT WEEKLY AMOUNT (1)~~	~~93~~
~~BENEFIT ADJUSTMENT START DATE~~	~~94~~
~~BENEFIT ADJUSTMENT END DATE~~	~~125~~
~~BENEFIT CREDIT CODE~~	~~126~~
~~BENEFIT CREDIT START DATE~~	~~127~~
~~BENEFIT CREDIT END DATE~~	~~128~~
~~BENEFIT CREDIT WEEKLY AMOUNT~~	~~129~~
CURRENT DATE DISABILITY BEGAN	144
CURRENT DATE LAST DAY WORKED	145
DEATH RESULT OF INJURY CODE	146
DENIAL REASON CODE (5)	173
GROSS WEEKLY AMOUNT (5)	174
RETURN TO WORK TYPE CODE (5)	189
OTHER BENEFIT TYPE AMOUNT ~~(4)~~ (5)(6)	215
OTHER BENEFIT TYPE CODE ~~(4)~~(5)(6)	216
PHYSICAL RESTRICTIONS INDICATOR (5)	224
RETURNED TO WORK WITH SAME EMPLOYER INDICATOR (5)	228
DENIAL EFFECTIVE DATE (5)	240

(1) Release 1 data element name differs.
(2) May use Code 90 (Multiple Body Parts) to reflect combined rating for any/all impairments.
(3) Use actual permanent disability rating at the time of initial payment of permanent disability benefits. For compromise and release cases, use permanent disability estimate as reported to the appropriate rating organization established under Insurance Code § 11750, et seq.

(4) For Release 1 only.
(5) For Release 2 only.
~~(4)~~ (6) Only for Other Benefit Type Codes 310 (Total Penalties) and 321 (Total Employee Interest).

Note: Final reports (MTC = FN) are required only for claims where indemnity benefits are paid. For medical-only claims, the final report would be reported under Subsection (g) (MTC = AN) with claim status = "closed."

(e) ~~Reserved for future rulemaking requiring the submission of medical bill/payment reports.~~ On and after July 1, 2005, claims administrators may annually submit to the WCIS on each claim with a date of injury on or after July 1, 2005, the following data elements for all medical services for which the claims administrator has received a billing or other notice of medical services provided.

DATA ELEMENT NAME	DN
JURISDICTION CLAIM NUMBER	5
INSURER FEIN	6
INSURER NAME	7
CLAIM ADMINISTRATOR MAILING POSTAL CODE	14
CLAIM ADMINISTRATOR CLAIM NUMBER	15
EMPLOYER FEIN	16
EMPLOYER NAME	17
DATE OF INJURY	31
EMPLOYEE SSN	42
EMPLOYEE LAST NAME	43
EMPLOYEE FIRST NAME	44
EMPLOYEE DATE OF BIRTH	52
EMPLOYEE GENDER CODE	53
CLAIM ADMINISTRATOR FEIN	187
CLAIM ADMINISTRATOR NAME	188
MANAGED CARE ORGANIZATION IDENTIFICATION NUMBER(1)	208
MANAGED CARE ORGANIZATION NAME (2)	209
UNIQUE BILL ID NUMBER	500
TOTAL CHARGE PER BILL (3)(4)	501
BILLING TYPE CODE	502
BILLING FORMAT CODE	503
FACILITY CODE	504
PROVIDER AGREEMENT CODE (5)	507
BILL SUBMISSION REASON CODE (6)	508
SERVICE BILL DATE(S) RANGE	509
DATE OF BILL	510
DATE INSURER RECEIVED BILL	511
DATE INSURER PAID BILL (3)	512
ADMISSION DATE	513
DISCHARGE DATE	514

CONTRACT TYPE CODE	515
TOTAL AMOUNT PAID PER BILL (3)	516
DRG CODE	518
PRINCIPAL DIAGNOSIS CODE	521
ICD-9 CM DIAGNOSIS CODE	522
PROCEDURE DATE	524
PRESCRIPTION BILL DATE	527
BILLING PROVIDER LAST/GROUP NAME	528
BILLING PROVIDER FIRST NAME	529
GATEKEEPER INDICATOR (7)	534
ADMITTING DIAGNOSIS CODE	535
BILLING PROVIDER PRIMARY SPECIALTY CODE (8)	537
BILL ADJUSTMENT GROUP CODE (3)(9)	543
BILL ADJUSTMENT REASON CODE (3)(10)(11)	544
LINE NUMBER	547
TOTAL CHARGE PER LINE (3)(4)(10)	552
PLACE OF SERVICE BILL CODE	555
DIAGNOSIS POINTER	557
REVENUE BILLED CODE	559
PRESCRIPTION LINE NUMBER	561
DRUG NAME	563
BASIS OF COST DETERMINATION CODE	564
TOTAL CHARGE PER LINE - RENTAL	565
TOTAL CHARGE PER LINE - PURCHASE	566
DME BILLING FREQUENCY CODE	567
DRUGS/SUPPLIES QUANTITY DISPENSED	570
DRUGS/SUPPLIED NUMBER OF DAYS	571
DRUGS/SUPPLIES BILLED AMOUNT	572
TOTAL AMOUNT PAID PER LINE (3)	574
REVENUE PAID CODE	576
DRUGS/SUPPLIES DISPENSING FEE	579
RENDERING LINE PROVIDER FEIN	586
RENDERING LINE PROVIDER FIRST NAME (12)	587
RENDERING LINE PROVIDER LAST/GROUP NAME (12)	589
RENDERING LINE PROVIDER NATIONAL PROVIDER ID (12)(13)	592
RENDERING LINE PROVIDER PRIMARY SPECIALTY CODE (12)	595
RENDERING LINE PROVIDER STATE LICENSE NUMBER (12)	599
PLACE OF SERVICE LINE CODE	600
PRESCRIPTION LINE DATE	604
SERVICE LINE DATE(S) RANGE (11)	605
INITIAL AMOUNT PAID	624
HCPCS PRINCIPLE PROCEDURE BILLED CODE	626
BILLING PROVIDER FEIN	629
BILLING PROVIDER STATE LICENSE NUMBER (8)	630
BILLING PROVIDER NATIONAL PROVIDER ID (13)	634
RENDERING BILL PROVIDER LAST/GROUP NAME	638
RENDERING BILL PROVIDER FEIN	642
RENDERING BILL PROVIDER STATE LICENSE NUMBER	643
RENDERING BILL PROVIDER SPECIALTY LICENSE NUMBER	649

RENDERING BILL PROVIDER PRIMARY SPECIALTY CODE	651
FACILITY NAME	678
FACILITY FEIN	679
FACILITY STATE LICENSE NUMBER	680
FACILITY MEDICARE NUMBER	681
FACILITY POSTAL CODE	688
MANAGED CARE ORGANIZATION FEIN (2)	704
MANAGED CARE ORGANIZATION POSTAL CODE	712
JURISDICTION PROCEDURE BILLED CODE (14)(15)	715
HCPCS MODIFIER BILLED CODE	717
JURISDICTION MODIFIER BILLED CODE (14)(15)(16)	718
NDC BILLED CODE	721
HCPCS LINE PROCEDURE PAID CODE	726
HCPCS MODIFIER PAID CODE	727
NDC PAID CODE	728
JURISDICTION PROCEDURE PAID CODE (14)	729
JURISDICTION MODIFIER PAID CODE (14)(16)	730
SERVICE ADJUSTMENT GROUP CODE (3)(9)	731
SERVICE ADJUSTMENT REASON CODE (3)(9)(11)	732
HCPCS BILL PROCEDURE CODE	737
(1) HCO claims only; required only when provided to claims administrator. (2) For HCO claims use HCO name in DN 209 and the FEIN of the sponsoring organization in DN 704. (3) Not required when claims administrator provides medical services to injured workers on a capitated basis under Labor Code § 4614 (b). (4) Optional on non-denied bills if amount paid equals amount charged. (5) For HCO claims use code P "Participation Agreement" (6) For medical services provided on a capitated basis under Labor Code § 4614 (b), use code 09 "Encounter." (7) Use to indicate whether the provider is the primary treating physician at the time services were rendered. (8) Does not apply if billing provider is an organization. (9) Required if charged and paid amounts differ. (10) Optional on denied bills, until the time that payment may be made. (11) For reporting of medical lien payments, use code 64 'Denial reversed per medical review.' (12) Optional if rendering provider equals billing provider. (13) To be provided following the assignment of a National Provider Identifier by the United States Department of Health and Human Services, Health Care Financing Administration ("HCFA"). (14) The codes for this data element are the codes that are set forth in the California Official Medical Fee Schedule, a publication of the State of California, Department of Industrial Relations (adopted pursuant to Labor Code § 5307.1 and Title 8, California Code of Regulations § 9790 et seq.). (15) Optional if procedure billed equals procedure paid. (16) Use when a modifier has been provided.	

(f) Notwithstanding the requirement in Subsection (b) to submit data elements omitted from the first report within 60 days from the date of transmission of the first report, when a claims administrator becomes aware of an error or need to update data

elements previously transmitted, or learns of information that was previously omitted, the claims administrator shall transmit the corrected, updated or omitted data to WCIS no later than the next submission of data for the affected claim.

(g) No later than January 31 of every year, commencing in 2001, claims administrators shall, for each claim with a date of injury on or after July 1, 2000 and with any payment in any benefit category, including medical, in the previous calendar year, report the total paid in each payment category through the previous calendar year by submitting the following data elements:

DATA ELEMENT NAME	DN
BENEFIT TYPE CODE	85
BENEFIT TYPE AMOUNT PAID	86
BENEFIT PERIOD START DATE	88
BENEFIT PERIOD THROUGH DATE	89
OTHER BENEFIT TYPE AMOUNT	215
OTHER BENEFIT TYPE CODE	216

Note: Final reports (MTC = FN) are required only for claims where indemnity benefits are paid. For medical-only claims, the final report would be reported under this subsection (MTC = AN) with claim status = "closed."

(h) (1) A claims administrator's obligation to submit copies of benefit notices to the Administrative Director pursuant to Labor Code Section 138.4 is satisfied upon determination by the Administrative Director that the claims administrator has demonstrated the capability to submit complete, valid, and accurate data as required under Subsection (d) and continued compliance with that subsection.

(2) Reserved.

(3) On and after July 1, 2005, a claims administrator's obligation to submit an Annual Report of Inventory pursuant to Title 8, California Code of Regulations Section 10104 is satisfied upon determination by the Administrative Director that the claims administrator has demonstrated the capability to submit complete, valid, and accurate data as required under Subsections (b), (d), (e), and (g), and continued compliance with those subsections.

(i) The data submitted pursuant to this section shall not have any application to, nor be considered in, nor be admissible into, evidence in any personal injury or wrongful death action, except as between an employee and the employee's employer. Nothing in this subdivision shall be construed to expand access to information held in the WCIS beyond that authorized in section 9703 and Labor Code section 138.7.

(j) Each claims administrator required to submit data under this section shall submit to the Administrative Director an EDI Trading Partner Profile at least thirty days prior to its first transmission of EDI data. Each claims administrator shall advise the Administrative Director of any subsequent changes and/or corrections made to the information provided in the EDI Trading Partner Profile by filing a corrected copy of the EDI Trading Partner Profile with the Administrative Director.

Authority: Sections 133, 138.4, 138.6, and 138.7, Labor Code.
Reference: Section 138.4, 138.6, and 138.7, Labor Code.

9703. Access To Individually Identifiable Information

(a) No person shall have access to individually identifiable data held in the WCIS except as provided in this section and subdivision ~~(c)~~ (c) of section 138.7 of the Labor Code.

(b) The Division of Workers' Compensation may obtain and use individually identifiable information for the following purposes:

(1) To create and maintain the WCIS, including the selection of claims to survey in order to obtain information not available from the data elements provided by claims administrators.
(2) To help select claims administrators for audits under section 129 of the Labor Code.
(3) To report the promptness with which claims administrators make payments.
(4) To electronically import names, addresses, and other information into Division of Workers' Compensation case~~s~~ files which would otherwise have to be key entered by agency staff.
(5) To conduct research related to the workers' compensation system for the purpose of carrying out the duties of the Division of Workers' Compensation or the Administrative Director.

(c) The following agencies may obtain individually identifiable information from the WCIS, in the manner set forth in a memorandum of understanding between the Administrative Director and the agency, for the purposes specified:

(1) The Division of Occupational Safety and Health may use individually identifiable information to help select employers for health and safety consultations and inspections.
(2) The Division of Labor Statistics and Research may use individually identifiable information to carry out its research and reporting responsibilities under Labor Code sections 150 and 156.

(3) The Department of Health Services may use individually identifiable information to carry out its occupational health and occupational disease prevention responsibilities under section 105175 of the Health and Safety Code.

(d) Upon written request to the Administrative Director, researchers employed by or under contract to the Commission on Health and Safety and Workers' Compensation agencies may obtain individually identifiable information from the WCIS, in the manner set forth in a memorandum of understanding between the Administrative Director, the commission, and the person or entity conducting research, for the purpose of bona fide statistical research.

(1) Any request from the commission for individually identifiable information under this subdivision shall include the identity of the person or entity conducting the research, the purpose of the research, the research protocol, the need for individually identifiable WCIS data, and an anticipated completion date for the research.

(2) Researchers under contract to the commission seeking individually identifiable WCIS data under this subdivision shall also submit to the Administrative Director written approval of the research protocol by an Institutional Review Board in the same manner as required under subdivision (e).

(3) Individually identifiable information obtained under this subdivision shall not be disclosed to the members of the commission.

(4) No individually identifiable information obtained by researchers under this subdivision may be disclosed to any other person or entity, public or private, for a use other than that research project for which the information was obtained.

(5) Researchers obtaining individually identifiable information under this subdivision shall notify the Administrative Director when the research has been completed. Within 30 days thereafter, the commission shall present evidence to the Administrative Director that the data collected has been modified in a manner so that the subjects cannot be identified, directly or through identifiers linked to the subjects.

~~(d)~~ (e) Individually identifiable information may be provided to other persons or public or private entities for the purpose of bona fide statistical research which does not divulge individually identifiable information concerning any employee, employer, claims administrator, or any other person or entity. Any request for individually identifiable information for this purpose shall include the identity of the requester, the purpose of the

research, the methods of research, and the need for individually identifiable WCIS data. The requester shall also submit written approval of the research protocol by an Institutional Review Board, under Title 45, Code of Federal Regulations, Part 46, Subpart A. "Approval" means a determination by the Institutional Review Board that the research protocol was reviewed and provides sufficient safeguards to ensure the confidentiality of individually identifiable information. Any agreement to permit use of the data shall be in writing between the requester and the Administrative Director. Note: The Division shall make available upon request a list of Institutional Review Boards known to the Division that have the authority to grant the required approval and that expressed willingness to review research proposals under this section.

~~(e)~~ (f) Each agreement or memorandum of understanding entered concerning the use of individually identifiable information by any agency, entity, or person shall specify the methods to be used to protect the information from unlawful disclosure, and shall include a warning to the receiving party that it is unlawful for any person who has received individually identifiable information from the Division of Workers' Compensation under this section to provide the information to any person who is not entitled to it under this section and Labor Code § 138.7.

~~(f)~~ (g) Nothing in this section shall be construed to exempt from disclosure any public record contained in an individual's file once an Application for Adjudication has been filed with the Workers' Compensation Appeals Board. This includes any data from an individual's file that are converted to or stored in an electronic format for the purpose of case processing and tracking.

~~(g)~~ (h) Nothing in this section shall be construed to exempt from disclosure WCIS data in a format that does not contain individually identifiable information.

Authority: Sections 127, 133, 138.4, 138.6, ~~and~~ 138.7, and 5450, Labor Code.
Reference: Sections 129, 138.4, 138.6, and 138.7, Labor Code.